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## FINAL RECOMMENDATIONS FOR THE OSTEOPATHIC MEDICAL BOARD

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### RECOMMENDATIONS OF THE JOINT SUNSET REVIEW COMMITTEE AND THE DEPARTMENT OF CONSUMER AFFAIRS (DEPARTMENT)

**ISSUE #1.** (CONTINUE REGULATION OF THE PROFESSION?) Should the licensing and regulation of Doctors of Osteopathy be continued?

**Recommendation #1:** *The Joint Committee and Department recommends continued state regulation of this profession.*

**Comments:** Like other medical care, osteopathic medicine requires a high level of skill. Licensure ensures that osteopaths have the necessary knowledge, skills, and abilities to provide care without causing harm to their patients. In addition, regulation of the profession creates an enforcement structure so that action can be taken when unsafe, fraudulent, or incompetent activities occur.

**ISSUE #2.** (CONTINUE WITH THE BOARD?) Should the Board be continued, or its role be limited to an advisory body and the remaining functions be transferred to the Department?

**Recommendation #2:** *The Joint Committee and the Department recommends retaining the Board as the agency responsible for regulating the practice of osteopathic care.*

**Comments:** The board structure has proven effective for the regulation of other health professions. The Department has not been presented with any information suggesting a need to change the current regulatory structure for the osteopathic profession.

**ISSUE #3.** (PLACE THE BOARD UNDER THE JURISDICTION OF THE DEPARTMENT LIKE OTHER HEALTH PROFESSIONAL LICENSING BOARDS?) Should the Osteopathic Medical Board be placed under the jurisdiction of the Department of Consumer Affairs like all other health-related professional licensing boards?

**Recommendation #3:** *Given the proven need for flexibility in modifying licensing laws and the potential benefits to the Board from the Department's expertise, the Department concurs with the recommendation of the Joint Committee that the Legislature take action to place an initiative on the ballot to move the Board into the Department's structure.*

**Comments:** The Osteopathic Medical Board is unusual among state regulatory entities since it is only one of two professional boards established by a voter-approved initiative, rather than by legislative

action. Created in 1922, the Board regulates the practice of osteopathic care and is completely independent of the Department, which distinguishes it from the state's other health professional licensing programs. As a consequence, it is not subject to any oversight or administrative process review within the executive branch, as are other licensing boards under the Department. The current structure also prevents the Board from utilizing the Department's regulatory expertise and the administrative economies of scale available to other Department programs. Also, there is some question as to whether the Legislature and the Administration can amend the governing statutes for the Board without voter approval. Thus, routine regulatory changes such as increasing fees, modifying licensing requirements, and updating the osteopathic scope of practice may require an additional, and unnecessary, approval process. Given the proven need for flexibility in modifying licensing laws and the potential benefits to the Board from the Department's expertise, the Department concurs with the Joint Committee recommendation that the Legislature take action to place an initiative on the ballot to move the Board into the Department structure.

**ISSUE #4. (SHOULD ALL GENERAL REQUIREMENTS FOR OTHER HEALTH-RELATED LICENSING BOARDS APPLY TO THIS BOARD?)** Should all general provisions (and future provisions) of the Business and Professions Code that apply to all other health-related licensing boards under the Department, apply to this Board?

***Recommendation #4:*** *The Joint Committee recommends that the Osteopathic Initiative Act should be amended if necessary, or statutory changes made, that will assure this Board will be subject to the same requirements as all other health practitioner licensing boards under the Business and Professions Code. Various statutory sections throughout the Business and Professions Code should also be consolidated into one chapter pertaining to Osteopathic practice as recommended by Legislative Counsel.*

**Comments:** Unlike the Chiropractic Initiative Act, there is direct authority under Section 3 of the Osteopathic Initiative Act for the Legislature to further amend or modify the act as necessary. This authority was granted to the Legislature in 1962 by voter approval. It does not appear that it would be necessary to place an initiative on the ballot to either move the Board under the jurisdiction of the Department or assure that it meet all the same requirements as all other health-related boards under the Department. However, legislation would still be necessary to assure that this Board was subject to these requirements. This would include cite and fine authority, inspection authority, injunctive relief, board and public member requirements, examination and review requirements, periodic sunset review, and all future requirements or changes made by the Legislature that apply to all health-related boards under the Department.

**ISSUE #5. (NEED FOR ADDITIONAL POSITION TO MANAGE AND MONITOR ITS ENFORCEMENT PROGRAM?)** The Board appears to have the need for one additional position for its enforcement program to improve the tracking of complaints and assure the efficient disposition of enforcement cases.

**Recommendation #5:** *The Joint Committee recommends that the Board should seek appropriate spending authority for an additional staff position to improve the tracking and disposition of enforcement cases. The Board’s current fund condition could support this additional position.*

**Comments:** The Board currently has 4 employees and sought budgetary approval for a fifth. Finance rejected the request. However, the Board currently lacks staff resources to perform a range of functions that could improve its ability to carry out its enforcement program, as well as prepare and analyze data related to its enforcement operations. For example, statistics presented to the Joint Committee had to be culled from paper records. The Board does not have staff resources to manage electronic data that would be valuable analytical information. Presently, the Board has ample fund resources, and fees are relatively low in comparison to what M.D.s pay in licensing fees to the Medical Board of California. The Medical Board, however, is able to carry out a more sophisticated enforcement program; it can track and monitor its cases better; it can manage its expenses better; and it can respond to requests for data better. D.O.s are equivalent practitioners of medicine, and it makes little sense to provide better tools to one regulator of physicians than to the other.

**ISSUE #6.** (ALLOW BOARD TO ACCESS RESERVE FUNDS OR RECEIVE IMMEDIATE APPROVAL OF BCP/DEFICIENCY REQUEST FOR ENFORCEMENT PURPOSES?) This Board, like others under the Department, has had to curtail desired enforcement activity due to lack of spending authority, even though its overall fund condition was stable and it had adequate reserves.

**Recommendation #6:** *This issue is being addressed as a crosscutting issue. As indicated, there should be a more efficient mechanism to allow boards to access necessary enforcement funds when higher than expected enforcement costs threaten to limit appropriate late-year enforcement activities.*

**Comments:** One problem characteristic of the licensing bodies that contract for investigative and prosecutorial services, is that late in the fiscal year spending authority may have been consumed by individual significant cases, or by a higher than expected volume of cases. As a consequence, enforcement activity falls off late in the year. This problem has plagued the Board numerous times in years past, although the Board asserts that it has not had to curtail enforcement activities recently.

This problem is particularly acute for relatively small boards or programs. When budgeting, governmental agencies need to be able to estimate a predictable level of activity and use cost assumptions based on averages to identify an appropriate level of spending authority. However, complex or unique individual cases or an unusually high volume year can overwhelm even the most carefully calculated “expected” spending estimate. When a program’s fund condition is sound, it is contrary to the interests of public protection to limit a regulatory body’s enforcement activity simply because more, or more complex, activity occurred than predicted. Nonetheless, this reality has occurred with regard to this Board – a regulatory agency charged with protecting the public from incompetent physicians.

**ISSUE #7. (SHOULD DISCIPLINARY CASES BE REFERRED TO A SPECIALIZED UNIT WITHIN THE ATTORNEY GENERAL’S OFFICE FOR MEDICAL RELATED CASES?)** The Board has been referring its cases to the Attorney General’s general licensing unit rather than to the Health Quality Enforcement (HQE) unit, which is used by the Medical Board and has investigators and attorneys who are considered specialists in health care issues.

**Recommendation #7:** *The Joint Committee recommends that the Board should refer its disciplinary cases to the Attorney General’s (AG’s) Health Quality Enforcement unit, if agreed to by the AG’s office and there is evidence that it would enhance the Board’s enforcement program.*

**Comments:** The Health Quality Enforcement (HQE) unit within the Attorney General’s office is not separately funded by the Medical Board of California (MBC). While virtually all of its work is dedicated to enforcing the Medical Practices Act against physicians and surgeons (MD’s), with the MBC as its client, those services are billed on a case by case basis to the MBC. Thus, the current financial structure of the HQE would not create subsidies from the MBC to the Board in the event HQE deputies handled Board prosecutions. Instead, as work performed by the HQE for whatever client is performed, it could be billed for that client. If workload increases, staffing could be increased.

The rationale for the HQE is that medical issues are unique, complex, and require specialists to most effectively handle enforcement cases. This is a reasonable approach that has worked well for the MBC. However, there appears to be no reason why disciplinary matters aimed at all physicians should not be handled by these specialists. As far as the public is concerned, there is no difference legally between Doctors of Osteopathy (D.O.) and MD’s. Each type of licensee can and does provide the full range of physician services to the public and presents the same types of risks to the public when incompetent, unprofessional, grossly negligent, or repeatedly negligent behaviors occur.

**ISSUE #8. (SHOULD THE OPTION FOR THE BOARD TO PROVIDE EITHER A STATE OR NATIONAL EXAMINATION BE ELIMINATED?)** The Board provides an option for applicants to pass a state examination or a comparable national examination administered by the National Board of Osteopathic Examiners. Very few applicants take advantage of the state examination, and the contractor who provided this examination has discontinued preparing the exam. If the option were continued, the Board would now be required to develop a new state examination.

**Recommendation #8:** *The Joint Committee recommends that the Board should seek legislation to delete the requirement that it provide either a state examination or national examination and instead allow the Board to determine what national examination is appropriate.*

**Comments:** In order for a D.O. applicant to become licensed as a physician in California, he/she must meet certain educational and training requirements, pass a written examination, and pass an oral/practical examination. The written examination requirement can be met in one of two ways: successful passage of the national boards, or successful passage of an examination administered by the Board. The Board has contracted with the National Board to prepare this California examination (as have a handful of other states.) However, as of November 1, 1999, this service will no longer be available.

In general, licensing examinations must be carefully crafted and validated, so that the test is a fair and reasonable basis to block or allow entry into a profession. That process can be very expensive. This is particularly true if the population of test takers is very small. In the Board context, very few applicants take advantage of the examination administered by the Board – the vast majority of applicants have taken and passed the comparable examination administered by the National Board of Osteopathic Examiners. From a cost-benefit perspective, it makes little sense to continue to provide a California-administered written examination in light of the substantial up-front costs necessary to develop such an examination. The existing examination statute reads as a permissive authority. Read in that light, the Board could simply cease to exercise that authority. However, counsel for the Board has suggested that the statute could be read to confer on applicants a choice of examination options, and that the Board could be forced to expend substantial resources to generate on its own an examination that would be minimally, if at all, different from the national boards. Counsel has suggested elimination of the offending language. [The Board recently introduced legislation to eliminate the requirement for the optional examination.]

**ISSUE #9. (CONTINUE TO REQUIRE REGISTRATION OF OSTEOPATHIC MEDICAL CORPORATIONS?)** The Board is currently required to register medical corporations that have physicians and surgeons licensed by the Board. The Board has indicated that it believes this requirement is no longer necessary.

***Recommendation #9:*** *The Joint Committee recommends that the Board should seek legislation to eliminate the requirement to register medical corporations that have physicians and surgeons licensed by the Board.*

**Comments:** Pursuant to Section 2454 of the Business and Professions Code, a medical corporation that has physicians and surgeons licensed by the Board must register with the Board and provide specified information. The Board has indicated that it believes this requirement is no longer necessary. Medical corporations were originally unique and designed to provide physicians with adequate security for claims against it, as well as for tax and benefit purposes. In recent years the requirements for registration has greatly lessened and the consumer/patient can now readily identify who is providing treatment to them. As such, no real public purpose is served by a registration requirement. The Board will continue to apply the fictitious name permit requirement as a means of assuring identify of practitioner irrespective of the fact that the provider is an individual or corporation. The Medical Board has already eliminated their statute requiring physicians to register their corporations. [The Board recently introduced legislation to eliminate this requirement.]

**ISSUE #10. (CHANGE COMPOSITION OF THE BOARD?)** The current composition of the Board includes five professional members and only two public members (seven total members). The Governor chooses all members of the Board. Most other health-related consumer boards have a better balance of public members to professional members, and all boards under the Department allow the Senate and Assembly to each choose a member of the board.

**Recommendation #10:** *The Joint Committee recommends that, since the licensee population of this Board is rather small, about 2100 active D.O.'s, the size of this Board should not be increased. Instead one of the professional members of the Board should be replaced by a public member, bringing the Board's composition to 4 professional members and 3 public members (seven total members). And, if not in direct conflict with the Initiative Act, one public member should be appointed by the Senate and one public member by the Assembly.*

**Comments:** The Joint Committee has consistently recommended providing a better balance of public members to professional members for health-related licensing boards. There are currently eight health-related consumer boards that have similar professional majorities, (one additional professional member over that of the public membership). Two health-related boards have a public majority. The only super-professional majority boards (with a 2 to 1 ratio) are the Medical and Dental boards.

Since the licensee population of this Board is rather small, about 2100 active D.O.'s, the size of this Board should not be increased. Instead one of the professional members of the Board should be replaced by a public member, bringing the Board's composition to 4 professional members and 3 public members (seven total members). And, if not in direct conflict with the Initiative Act, the Senate and Assembly should each be able to choose one of the public members, since all other boards under the Department permit the Legislature to appoint two public members.